**DEPARTMENT OF HEALTH AND FAMILY SERVICES**
Division of Health Care Financing
HCF 11077 (12/04)

**STATE OF WISCONSIN**

**WISCONSIN MEDICAID**

# PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR NON-STEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDS)

**INSTRUCTIONS:** Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) Completion Instructions (HCF 11077A).

Dispensing providers are required to have a completed PA/PDL for NSAIDs form signed by the prescriber before calling Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) or submitting a paper PA request.

## SECTION I — RECIPIENT INFORMATION

1. Name — Recipient (Last, First, Middle Initial)
2. Date of Birth — Recipient
3. Recipient Medicaid Identification Number

## SECTION II — PRESCRIPTION INFORMATION

4. Drug Name
5. Strength
6. Date Prescription Written
7. Directions for Use
8. Diagnosis — Primary Code and/or Description
9. Name — Prescriber
10. Drug Enforcement Agency Number
11. Address — Prescriber (Street, City, State, Zip Code)
12. Telephone Number — Prescriber

## SECTION IIIA — CLINICAL INFORMATION FOR NSAID COX-2

13. Has the recipient tried and failed on a preferred generic NSAID or had an adverse drug reaction? ❑ Yes ❑ No
    If yes, what preferred generic NSAID(s) has failed or what adverse reaction has the recipient experienced?
14. Is the NSAID being prescribed for a chronic, non-acute condition? ❑ Yes ❑ No
    What condition is the NSAID being prescribed to treat?
15. Does the recipient have any of the following risk factors: age over 65, a history of ulcer or gastrointestinal (GI) bleeding, or currently taking anti-coagulants? ❑ Yes ❑ No
    If yes, indicate the risk factor below.

## SECTION IIIB — CLINICAL INFORMATION FOR NSAID NON-COX-2

16. Has the recipient tried and failed on a preferred generic NSAID or had an adverse drug reaction? ❑ Yes ❑ No
    If yes, what preferred generic NSAID(s) has failed or what adverse reaction has the recipient experienced?

*Continued*

## SECTION IIIC — CLINICAL INFORMATION FOR NON-PREFERRED NSAID

17. Has the recipient tried and failed on or had an adverse reaction to a preferred generic NSAID and either a COX-2, Mobic®, or Ponstel®? ❑ Yes ❑ No
If yes, what preferred generic NSAID and COX-2, Mobic®, or Ponstel® have failed or what adverse reaction has the recipient experienced?

| 18. **SIGNATURE** — Prescriber | 19. Date Signed |
|---|---|
| | |

## SECTION IV — FOR DISPENSING PROVIDERS USING STAT-PA

| 20. National Drug Code (11 digits) | 21. Days' Supply Requested* |
|---|---|
| | |

22. Wisconsin Medicaid Provider Number (Eight digits)

23. Date of Service (MM/DD/YYYY) (For STAT-PA requests, the date of service may be up to 31 days in the future and / or up to 14 days in the past.)

24. Place of Service (Patient Location) (Use patient location code "00" [Not specified], "01" [Home], "04" [Long Term/Extended Care], "07" [Skilled Care Facility], or "10" [Outpatient])

25. Assigned Prior Authorization Number (Seven digits)

| 26. Grant Date | 27. Expiration Date | 28. Number of Days Approved |
|---|---|---|
| | | |

*Days' supply requested equals the total number of days requested for the PA. For example, for a one-year PA, providers should enter "365."

## SECTION V — ADDITIONAL INFORMATION

29. Include any additional information in the space below. For example, providers may include that this PA request is being submitted for a recipient who was granted retroactive eligibility by Wisconsin Medicaid, BadgerCare, or SeniorCare.

Reset Form